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WHOLE WOMAN'S HEALTH; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; NOVA HEALTH SYSTEMS d/b/a REPRODUCTIVE SERVICES; SHERWOOD C. LYNN, JR., M.D.; PAMELA J. RICHTER, D.O.; and LENDOL L. DAVIS, M.D., on behalf of themselves and their patients,

Petitioners,

—v.—

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES; MARI ROBINSON, EXECUTIVE DIRECTOR OF THE TEXAS MEDICAL BOARD, in their official capacities,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF FREEDOM AND INDIVIDUAL RIGHTS IN MEDICINE (FIRM), DR. AMESH ADALJA, DR. PAUL HSIEH, DR. KAREN SALMIERI, AND JACOB SULLUM AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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INTERESTS OF AMICI CURIAE

The *amici curiae* on behalf of which this brief is submitted are physicians and journalists who are long-standing advocates for libertarian principles. *Amici* have joined to share their concern regarding unjustifiable health care regulations that put individual liberty and free market principles at risk.[1]

Freedom and Individual Rights in Medicine ("FIRM") is a web publication dedicated to promoting and providing information about the philosophy of individual rights, personal responsibility, and free market economics in health care.

Dr. Amesh Adalja is an infectious disease specialist and clinical assistant professor at the University of Pittsburgh Medical Center.[2] He is board certified in internal medicine, emergency medicine, infectious diseases, and critical care medicine. As a journalist and regular contributor to *Forbes*, he writes about capitalism, individual rights, and health care.

Dr. Paul Hsieh is a radiologist in the Denver area and FIRM's co-founder. As a journalist and regular contributor to *Forbes*, Dr. Hsieh covers health care and economics from a free-market perspective.

Dr. Karen Salmieri is a radiologist in New Jersey specializing in abdominal and pelvic imaging,

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[1] Pursuant to Supreme Court Rule 37.3(a), all parties have consented to the filing of this brief. No counsel for a party authored the brief in whole or in part and no person other than the *amici* or their counsel made a monetary contribution to the preparation and submission of this brief.

[2] Institutional affiliation listed for purposes of identification only.

including prenatal ultrasound and MRI. She graduated with honors from Yale University School of Medicine, and believes that individuals should have the freedom to make their own health care and family planning decisions.

Jacob Sullum is a senior editor at *Reason* magazine and Reason.com and a nationally syndicated columnist. Mr. Sullum's weekly column is carried by newspapers across the U.S., including the *New York Post* and the *Chicago Sun-Times*. His work also has appeared in *The Wall Street Journal*, *USA Today*, *The New York Times*, the *Los Angeles Times*, the *San Francisco Chronicle*, *National Review*, and many other publications. Mr. Sullum is a frequent guest on TV and radio networks, including Fox News Channel, CNN, and NPR. He is a graduate of Cornell University, where he majored in economics and psychology.

SUMMARY OF ARGUMENT

A free market provides consumers of medical care with an increased supply of high-quality, affordable services from which to choose. Competition promotes innovation, resulting in the availability of a variety of services tailored for personal preferences and needs. Unjustifiable regulations decrease the quality and quantity of services available while increasing their price. In the context of abortion, such regulations not only distort the market for and circumscribe access to the relevant services by dictating how physicians and other health care providers practice medicine; they also undermine a patient's liberty, autonomy, and ability to make health care decisions responsibly.

The State of Texas claims that its House Bill 2 ("HB2") was enacted "to raise standards of care and

ensure the health and safety of all abortion patients." See Br. in Opp. at 3, No. 15-274 (Oct. 2015). Not quite. HB2, specifically its admitting-privileges requirement[3] and ambulatory-surgical center ("ASC") requirement,[4] is an unprecedented interference in the already overregulated market for abortion services. HB2 and similar regulations compound the injury to liberty and free enterprise. In the view of *amici*, the health and safety of abortion patients would be best served by a free market constricted only by evidence-based regulations—in other words, regulations based exclusively on sound scientific research.

ARGUMENT

In the context of health care, government policies should give individuals the right to make their own decisions.[5] A free market in health care

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[3] The "admitting-privileges requirement" provides that "[a] physician performing or inducing an abortion[] must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that [] is located not further than 30 miles from the location at which the abortion is performed or induced" TEX. HEALTH & SAFETY CODE ANN. § 171.0031(a)(1)(A).

[4] The ASC requirement amends the existing framework for licensing abortion providers under Texas law to provide that, "the minimum standards for an abortion facility [codified in Chapter 139 of Title 25 of the Texas Administrative Code] must be equivalent to the minimum standards for ambulatory surgical centers [codified in Chapter 135 of the same Title]." TEX. HEALTH & SAFETY CODE ANN. § 245.010(a).

[5] See MICHAEL F. CANNON & MICHAEL D. TANNER, HEALTHY COMPETITION: WHAT'S HOLDING BACK HEALTH CARE AND HOW TO FREE IT (2d. ed. 2007)at 12; see also M. Joseph Sirgy *et al.*, *Consumer Sovereignty in Healthcare: Fact or Fiction?*, J. OF BUS. ETHICS (2011) (explaining that the libertarian approach to

services, like any other free market, respects the sovereignty of patients to compare options for products and services and to decide, often in consultation with their physicians, what is best for them. The result is increased efficiency and access without compromised quality.[6]

Liberalization of health care markets, including the market for abortion services, would increase the supply of physicians and allied health professionals, promote experimentation with new practice settings and modes of delivery, and increase competition, thereby providing patients with more and better choices.[7] Government over-regulation, however, undermines the critical benefits of a free market— (1) higher-quality services at lower prices, (2) competition and innovation, and (3) diverse services tailored for personal preferences and needs. Over-regulation does not reduce demand for services, and thus the subsequent reduction in supply will cause patients (particularly poor patients) to either delay treatment or turn to riskier forms of treatment.

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health care stresses equal access to rights with an emphasis on free-market-based solutions).

[6] Lesley H. Curtis & Kevin A. Schulman, *Overregulation of Health Care: Musings on Disruptive Innovation Theory*, L. & CONTEMP. PROBS., Vol. 69:195, 201 (2006), http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1401&context=lcp.

[7] See CANNON & TANNER, *supra* note 5 at 140-141; see also *id.* at 5 ("When these conditions of a competitive market are met, individual choice actually promotes lower prices and higher quality The result is a market process that makes health care of ever-increasing quality available to an ever-increasing number of consumers.").

I. UNJUSTIFIABLE HEALTH REGULATIONS IMPEDE PATIENTS' CHOICES BY REDUCING SUPPLY AND INCREASING COST OF SERVICES

In a free, competitive market, patients have an increased supply of high-quality and low-cost products, services, and providers.[8] Patients, as consumers of health care services and products, have the ability to dictate which services and products are available. Likewise, the supply of medical providers is enhanced when medical professionals have the right to choose their areas of practice, to run their practices as they choose, and to embrace innovation.[9] Unjustifiable government regulation creates obstacles to free market processes,[10] resulting in increased costs and decreased supply without

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[8] See D. Eric Schansberg, *Envisioning a Free Market in Health Care*, CATO J., Vol. 31, No. 1 (Winter 2011) ("Freer markets would mean far less subsidization and regulation of the transactions between insurers, providers, and consumers. The result would be more competition, more choice, and lower costs."), http://www.realclearmarkets.com/blog/cj31n1-2.pdf.

[9] See, *e.g.*, Paul Howard & Yevgeniy Feyman, *Rhetoric and Reality The Obamacare Evaluation Project: Access to Care and the Physician Shortage*, Ctr. for Med. Progress at the Manhattan Inst., No. 15 (June 2013) at p. 3 (explaining that addressing market incentives would help to rebalance supply and demand for primary care physicians); see also CANNON & TANNER, *supra* note 5, at 13.

[10] For example, certificate-of-need ("CON") programs have been criticized for restricting entry and limiting the provision of medical services, while increasing costs. See Thomas Stratmann & Jake Russ, *Do Certificate-of-Need Laws Increase Indigent Care?*, Mercatus Ctr., Geo. Mason Univ., Working Paper No. 14-20 (July 2014).

providing improvements in health care quality or availability.[11]

Regulations such as the ASC requirement of HB2 force established clinics to comply with costly and arbitrary requirements, disconnected from patient safety. See *Whole Woman's Health* v. *Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014). For example, the ASC requirements include minimum square footage, physical requirements (such as electrical, heating, ventilation, air conditioning, and plumbing requirements), staffing mandates, and parking design. *Id.* at 682. These requirements apply equally to clinics that provide only medical abortions, a type of non-surgical abortion in which pharmaceutical drugs are used to induce a miscarriage. As the District Court found, the extraordinary expense required for a clinic to comply with HB2 is prohibitive. *Id.* Converting a clinic to an ambulatory surgical center would cost over $1 million, and constructing a new clinic would likely exceed $3 million. *Id.* Even if providers could raise the funds for construction or renovation, the clinic's annual operating costs would increase by $600,000 to $ 1 million. J.A. 208-09. It is difficult for abortion providers to raise prices to cover these increased costs, because many women seeking abortions are price sensitive due to lack of resources and lack of insurance coverage.[12] Abortion clinics that cannot meet these costs will close, and few, if any, new

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[11] Curtis & Schulman, *supra* note 6; see also CANNON &TANNER, *supra* note 5, at 10, 138.

[12] See, *e.g.*, Carolyn Jones, *Need an Abortion in Texas? Don't Be Poor*, TEX. OBSERVER (May 8, 2013), http://www.texasobserver.org/need-an-abortion-in-texas-dont-be-poor/.

clinics will open. *Lakey*, 46 F. Supp. 3d at 682. Extensive regulations targeting abortion providers on the pretense of health and safety have distorted the clinic infrastructure on which women depend,[13] and HB2 will further accelerate clinic closures, leaving patients with even fewer options than they already have.

The regulations at issue in HB2 will reduce the supply not only of clinics, but also of doctors willing and able to provide abortion services.[14] The admitting-privileges requirement, which again is applicable to providers of medical abortions, is not appropriately justified by credible medical or health evidence. See *Lakey*, 46 F. Supp. 3d at 685. Uncontroverted evidence has shown that complications from abortions are "both rare and rarely dangerous." *Planned Parenthood of Wisconsin, Inc.* v. *Schimel*, No. 15-1736, 2015 U.S. App. LEXIS 20369, at *11 (7th Cir. Nov. 23, 2015); see also *Lakey*, 46 F. Supp. 3d at 685. Moreover, there is no reason to believe that the health and safety of women who have abortions are endangered if their doctors do not have admitting privileges. As the Seventh Circuit recently explained, "A woman who experiences complications from an abortion

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[13] See Linda Greenhouse & Reva B. Siegel, *Casey and the Clinic Closings: When 'Protecting Health' Obstructs Choice*, 125 YALE L.J. (*forthcoming* 2016), http://graphics8.nytimes.com/packages/pdf/opinion/greenhouse/CaseyClinic.pdf.

[14] LORI FREEDMAN, WILLING AND UNABLE: DOCTORS' CONSTRAINTS IN ABORTION CARE (2010) at 37 (factors that influence whether physicians provide abortion care include not only moral convictions but also constraints on abortion practices where they work and the extent to which they viewed abortion care as a professional responsibility).

(either while still at the clinic where the abortion was performed or at home afterward) will go to the nearest hospital, which will treat her regardless of whether her abortion doctor has admitting privileges." *Schimel*, 2015 U.S. App. LEXIS 20369, at *9-10.

Neither improving health nor safety of patients, the admitting privileges requirement of HB2 artificially restricts the limited supply of physicians who provide abortion services,[15] in the midst of a larger shortage of specialty and primary care physicians.[16] This is an unjustifiable burden on a market in which physicians are already regulated by compulsory occupational licensing laws. While this brief seeks to explain why the challenged provisions of HB2 are flawed regardless of their stated purpose, overwhelming evidence points to the pretextual nature of the purported health interest. See *Lakey*, 46 F. Supp. 3d at 685; see also *Schimel*, 2015 U.S. App. LEXIS 20369, at *35-36. In both the occupational licensing context and the admitting privileges context, regulations that do not further patient health and safety serve to restrict the market in furtherance of outside interests (*i.e.*, creating obstacles for women seeking abortion care and

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[15] *Id.* at 37 (describing a 2008 national survey finding only 22 percent of ob-gyns in the United States had performed an abortion in the previous year).

[16] See, *e.g.*, Howard & Feyman, *supra* note 9, at 3-4, 6-7 (describing the negative impact on patients' access to care, particularly in areas already experiencing a physician shortage, caused by unnecessary limitations on the ability of non-physician medical professionals to provide certain services), http://www.manhattan-institute.org/pdf/mpr_15.pdf.

protecting the financial interests of licensed professionals).[17]

Here, under the pretense of physician screening and credentials, hospitals and their internal committees will be statutorily placed in a market-altering position of power. As the District Court found, doctors in Texas have been denied privileges for reasons not related to clinical competency. See *Lakey*, 46 F. Supp. 3d at 685. This remains true of similar admitting privileges requirements in other states. For example, some hospitals require evidence of "inpatient activity," such as a minimum number of patients that must be admitted to the hospital or a minimum number of babies that must be delivered each year by that particular physician. See, *e.g.*, Pl. Exh. 057 at 3.5.15 (Record 3377, 3378) (requiring physicians with active admitting privileges to use the hospital for "at least 24 major procedures annually"); see also *Schimel*, 2015 U.S. App. LEXIS 20369, at *71. Conditioning the grant of admitting privileges on being qualified to perform procedures that abortion providers may never perform functions as an arbitrary restriction

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[17] See, *e.g.*, Morris M. Kleiner, *Occupational Licensing*, 4(4) J. OF ECON. PERSP. 189, 192 (Fall 2000) (explaining that through occupational licensing, members of a regulated occupation can protect their financial interests by implementing restrictions that limit new entrants); *cf.* Edward J. Timmons & Anna Mills, *Bringing the Effects of Occupational Licensing into Focus: Optician Licensing in the United States*, Mercatus Working Paper, Mercatus Ctr. Geo. Mason Univ. (Feb. 2015) (explaining that imposing occupational licensing standards does not guarantee a positive experience for all consumers, as it may reduce the quality of service, lead to less incentive to innovate and improve, and result in higher costs), http://mercatus.org/sites/default/files/Timmons-OpticianLicensing.pdf.

on the supply of providers. See *Schimel*, 2015 U.S. App. LEXIS 20369, at *71.

As has already happened in several states, unjustifiable regulations, such as HB2's ASC and admitting privileges requirements, will make accessing abortion services more expensive and available only from either: (1) providers willing and able to overcome extreme hurdles in order to ensure women's access to abortion;[18] or (2) "rogue providers," who avoid costs associated with regulatory compliance, notwithstanding increased demand for their services due to the shrinking market of abortion providers.[19] Such restrictions in an already-distorted market facing a provider shortage will result in a free market failure and an abrogation of individual choice.

In contrast, a competitive free market in some states has increased access to and options for early and safe abortions. For example, in California, recent reforms have created a freer market by permitting women to obtain abortion care from nurse practitioners, physician assistants, and nurse midwives at local clinics.[20] In New York, the Reproductive Health Access Project works directly

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[18] See, *e.g.*, CAROLE JOFFE, DISPATCHES FROM THE ABORTION WARS: THE COSTS OF FANATICISM TO DOCTORS, PATIENTS, AND THE REST OF US (2009) at 60.

[19] For example, Kermit Gosnell provided illegal abortions in Pennsylvania, a state with among the most restrictive abortion laws in the nation. *In re County Investigating Grand Jury XXIII*, Misc. No. 9901-2008 (Pa. C.P. Phila. filed Jan. 14, 2011).

[20] Assembly Bill 154; see also Tracy A. Weitz, et. al., *Safety of Aspiration Abortion Performed by NPs, CNWs, and PAs under a California Legal Waiver*, 103(3) AM. J. PUB. HEALTH 454 (March 2013), http://www.ncbi.nlm.nih.gov/pubmed/23327244.

with primary care providers, helping them integrate abortion, contraception, and miscarriage management into their practices so that patients can receive essential health care from their own primary care clinicians.[21] Studies have found that low-income and minority women are more likely to be cared for by nurse practitioners and physician assistants than by obstetricians and gynecologists,[22] and thus, expanding access to early abortions by increasing the number and type of health care professionals providing services affords more women the opportunity to obtain care without the additional costs associated with delay and extensive travel in obtaining treatment.[23] Similar innovations should be encouraged through further liberalization, not over-regulation.

II. UNJUSTIFIABLE HEALTH REGULATIONS STIFLE COMPETITION AND INNOVATION IN SERVICE DELIVERY AND QUALITY IMPROVEMENT

A free market approach to health care fosters competition and innovation. Innovations in health care allow tasks that historically could be performed only by specialists in centralized locations to be performed by less-costly providers, or even patients themselves, in more convenient, less-expensive

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[21] Reproductive Health Access Project, http://www.reproductiveaccess.org/about/ (last visited Dec. 30, 2015). Currently there are local networks of and partners with the Reproductive Health Access Project on the East Coast, the Midwest, and the West Coast.

[22] See Weitz, *supra* note 20.

[23] See *id.*

settings.[24] When the government "limits experimentation and learning in the marketplace, [it] inhibits the competitive discovery process."[25] Regulations may have the unintended consequence of preventing alternatives from reaching the marketplace, thereby leaving consumers and patients worse off.[26]

Regulatory distortion in the market for abortion services already has deprived women of innovations that would better serve their health and safety by making early abortion more easily accessible. One such innovation over the past two decades has been medical abortion, an easy, private, and efficient method of obtaining an abortion.[27] The increased availability of medical abortion has correlated with a trend toward earlier abortion,[28] in line with abortion patients' and the public's preferences for early abortions.[29]

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[24] See Curtis & Schulman, *supra* note 6, at 201 (describing innovations in health care).

[25] CANNON & TANNER, *supra* note 5, at 51.

[26] Curtis & Schulman, *supra* note 6.

[27] See Heather D. Boonstra, *Medication Abortion Restrictions Burden Women and Providers—and Threaten U.S. Trend Toward Very Early Abortion*, *Guttmacher Pol'y Rev.*, Vol. 16, No. 1 (Winter 2013), https://www.guttmacher.org/pubs/gpr/16/1/gpr160118.html.

[28] See *id.* (About nine in ten abortions occur in the first 12 weeks of pregnancy, and a large majority (73%) now occur in the first nine weeks).

[29] See *id.* (citing a Guttmacher study that found that, regardless of when they had their procedure, approximately 60% of women having abortions would have preferred to have their abortions earlier).

Another corresponding innovation is the availability of telemedicine, where a physician is at one geographical location, a patient is at a different geographical location, and the two communicate through a secure audio-visual connection. Telemedicine can be used to improve women's access to safe, early, and effective medical abortions by eliminating the need to travel long distances to see a physician. See, *e.g.*, *Planned Parenthood of the Heartland, Inc.* v. *Iowa Bd. of Med.*, 865 N.W.2d 252, 266 (Iowa 2015).

Unjustifiable regulations in numerous states have reversed this trend toward earlier abortions. Notwithstanding overwhelming support for expanding use of telemedicine,[30] access to medical abortion via telemedicine has been restricted through the adoption of unjustifiable and disparate regulations. See, *e.g.*, *id.* at 259. Additionally, Texas has restricted the availability of medical abortion by requiring adherence to an outdated FDA protocol. *See* TEX. HEALTH & SAFETY CODE ANN. §§ 171.012.a.4, 171.063.e (West 2014). Texas' regulations are inconsistent with evidence-based off-label use[31] and physician preference.[32] Although

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[30] See, *e.g.*, Bill Frist, *Telemedicine Is a Game-Changer for Patients, the System*, FORBES (Mar. 12, 2015), http://www.forbes.com/sites/billfrist/2015/03/12/telemedicine-is-a-game-changer-for-patients-the-system/.

[31] When medical abortion was first approved by the FDA, the drug label established dosage amounts for the two drugs (Mifeprex and misoprostol), specified that treatment required three office visits, and mandated that the drugs be administered only in a clinic, medical office, or hospital, by or under the supervision of a physician. Soon after the FDA approved medical abortion, providers began adopting evidence-based regimens that varied from the FDA label (called "off-label

such restrictions have stemmed the use of medical abortion[33] and reduced the options available to women, they do not lessen the demand for abortion. Thus, women who might have elected medical abortion very early in their pregnancy are increasingly resorting to later, surgical abortions.[34] Unjustifiable regulations such as HB2 operate in conjunction with these other regulations, unnecessarily impeding a patient's liberty to choose safe and effective services.

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use"). The off-label use reduced dosage amounts, shortened the interval between medications, and permitted the drugs to be administered by non-physician providers and taken by women at home. See Liz Borkowski et. al *Medication Abortion: Overview of Research & Policy in the United States*, Jacobs Inst. of Women's Health, Geo. Wash. Univ. (Dec. 2015). The "off-label" protocol for medical abortion is neither dangerous nor unproven. *Cf.* Cato Handbook for Policymakers, Ch. 15 *Health Care Regulation* at 160 (explaining that off-label use often becomes the standard of care accepted by doctors, scientists, and other authoritative sources)

[32] Practicing doctors strongly prefer the evidence-based off-label regimen, because, for example, the older, higher dosages make the medications harder to tolerate. See, *e.g.*, *Planned Parenthood* v. *Humble*, 753 F.3d 905, 907-08 (9th Cir. 2014).

[33] In Texas, within 6 months of enactment of strict abortion regulations, including regulations for medical abortions, medical abortions declined by 70%. See Wendy R. Sheldon & Beverly Winikoff, *Mifepristone label laws and trends in use: recent experiences in four US states*, Contraception 92 (2015) 182-185, http://www.contraceptionjournal.org/article/S0010-7824(15)00255-3/pdf.

[34] *Id.*; see also Boonstra, *supra* note 27.

III. UNJUSTIFIABLE HEALTH REGULATIONS DENY PATIENTS THE LIBERTY TO CHOOSE SERVICES BEST-SUITED FOR THEIR INDIVIDUAL NEEDS

A market process that promotes the availability of alternatives in health care is respectful of the freedom of doctors and patients to make health care decisions according to individual circumstances and personal preferences.[35] The government should not, through over-regulation, deny patients the liberty and autonomy to make important health care decisions.[36] Over-regulation, resulting in a "one-size-fits-all" model, deprives patients of their individual choice by reducing the supply of providers, increasing costs, and stifling innovation.[37]

For abortion patients, this means that they will no longer have a "choice within a choice" among various abortion care models and providers. A patient's decision may be influenced not only by price and location, but by other variables such as aesthetics, availability of counseling services, ability to be accompanied by partners or friends, and

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[35] CANNON & TANNER, *supra* note 5, at 127.

[36] See *id.* at 13-14; see also *id.* at 150-51 ("[H]ealth care is a special area of the economy. Unlike software, wireless communications, or banking, health care involves very emotional decisions, which often entail matters of human dignity, life, and death." The "gravity of these matters" is not a reason "to divert power away from individuals and toward government." Rather, the "special nature of health" emphasizes the need to increase each patient's "sphere of autonomy.").

[37] *Id.* at 5.

provision of aftercare.[38] A free market allows providers to compete and innovate by offering the most comfortable surroundings, the best-trained staff, and the most affordable prices.[39] For example, some providers offer services where examination rooms have soft music piped in, overhead lights are on a dimmer, artwork and motivational quotes hang on brightly painted walls, and aftercare includes warm tea, blankets, and heating pads.[40]

Of course, if a woman chooses to have an abortion in a hospital or an ASC and is willing and able to pay more for that service, she is free to make that choice. But she should not be required to do so. Alternatives should be available for women who prefer to obtain affordable abortion care in a comfortable setting. If the negative regulatory trend continues, with unjustifiable restrictions such as the ASC and admitting privileges requirements implemented in states across the country, abortion patients will no longer be able to make informed decisions among differentiated abortion care providers. Instead, all abortion patients will be forced to purchase more expensive care at a facility

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[38] See Andrea Grimes, *Another Choice Lost: HB 2 Targets Most of Texas' Independent Abortion Providers,* RH Reality Check (Aug. 28, 2014), http://rhrealitycheck.org/article/2014/08/28/another-choice-lost-hb-2-closes-texas-independent-abortion-providers/.

[39] Esmé E. Deprez, *How State Governments Are Regulating Away Abortion*, BLOOMBERG (Jan. 17, 2013) (as the owner of three clinics in the Detroit area explained, "We're not trying to sell it to someone who doesn't want one, but for someone who wants an abortion, we want them to choose us."), http://www.bloomberg.com/bw/articles/2013-01-17/how-state-governments-are-regulating-away-abortion.

[40] See, *e.g.*, *id.*; see also Grimes, *supra* note 38.

meant for invasive operations and potentially located hundreds of miles from home. Simply, these regulations undermine advances in the provision of individualized care, ignore patients' preferences, and eliminate options through which patients have the liberty to choose safe and effective early abortions.

IV. UNJUSTIFIABLE REGULATIONS DO NOT REDUCE DEMAND FOR MEDICAL SERVICES, BUT BY REDUCING SUPPLY OF SAFE AND AFFORDABLE SERVICES, THESE REGULATIONS HARM PATIENTS' HEALTH AND SAFETY

Government interventions, despite their stated goals of improving the standard of care and ensuring the health and safety of consumers, often produce the opposite effect and result in more, not less, risk.[41] Countervailing risks can exceed the reduction in risks that were originally targeted by government regulations,[42] and risks could be transferred to or increased on some groups of consumers more than others.[43] Particularly in the

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[41] *Cf.* Richard Epstein, *In Defense of 'Old' Public Health: The Legal Framework for the Regulation of Public Health*, (John M. Olin Program in Law and Economics Working Paper No. 170, 2002), http://chicagounbound.uchicago.edu/law_and_economics/259/.

[42] See Sherzod Abdukadirov, *The Unintended Consequences of Safety Regulation*, Mercatus Research (June 4, 2013) ("[P]olicies attempting to reduce risk in one area often increases risks elsewhere. In some cases, the increases in countervailing risks may even exceed the reduction in targeted risks, leading to a policy that does more harm than good."), http://mercatus.org/sites/default/files/Abdukadirov_Unintended Consequences_v1.pdf.

[43] See *id.* ("One possible source of unintended consequences [of regulation] is the differing ability of various groups to advance

context of health care, over-regulation and interference with the free market may make it more difficult and riskier for the poor to obtain needed services.[44]

As explained above, certain provisions of HB2 will result in significantly reducing the supply of abortion providers in Texas,[45] while increasing the cost of abortion services. When first-trimester abortion services are scarce or costly, women experience delays in obtaining treatment, resulting in more expensive, more complicated, and less-available second-trimester abortions. See, *e.g.*, *Schimel,* 2015 U.S. App. LEXIS 20369, at *28 ("For the longer the waiting list for an abortion, the more women who want to have early-term abortions will perforce end up having late-term ones, which are more dangerous."). The delay in and burden of obtaining safe and early abortion services may cause some women to resort to self-inducement or even illegal, black market services.[46]

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their interests. Risk trade-offs often involve transferring risks from one group to another. Direct risks may fall on concentrated interests, while countervailing risks may affect a group that has fewer resources or is less organized.").

[44] CANNON & TANNER, *supra* note 5, at 14 ("By hindering the competitive process, government actually makes it more difficult for the medically needy to obtain care.").

[45] If the Fifth Circuit's decision is affirmed, 10 or fewer clinics would remain open in Texas. See Letter from S. Toti, Counsel for Appellees to Lyle W. Cayce, Clerk of Court, U.S. Court of Appeals for the Fifth Circuit, June 12, 2015.

[46] See Olga Khazan, *Texas Women Are Inducing Their Own Abortions*, THE ATLANTIC (Nov. 17, 2015) (methods of self-inducement include illegally purchasing abortion drugs, taking herbs or homeopathic remedies, or getting hit or punched in the abdomen),

As the District Court found, "[h]igher health risks associated with increased delays in seeking early abortion care, risks associated with longer distance automotive travel on traffic-laden highways, and the act's possible connection to observed increases in self-induced abortions almost certainly cancel out any potential health benefit." *Lakey*, 46 F Supp. 3d at 684. The challenged HB2 regulations will do more harm than good, having the opposite effect of their stated purpose, which is to raise standards of care and ensure the health and safety of all abortion patients.

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http://www.theatlantic.com/health/archive/2015/11/texas-self-abort/416229/; see also Emily Bazelon, *A Mother in Jail for Helping Her Daughter Have an Abortion*, N.Y. TIMES MAG. (Sept. 22, 2014), (reporting that a Pennsylvania mother of three is currently serving time in prison for helping her teenage daughter purchase abortion-inducing drugs from the internet), http://www.nytimes.com/2014/09/22/magazine/a-mother-in-jail-for-helping-her-daughter-have-an-abortion.html.

CONCLUSION

The health and safety of abortion patients would be best served by a free market constricted only by evidence-based regulations. The challenged HB2 regulations, which are unsupported by evidence, mandate that patients obtain procedures in more expensive facilities and prohibit patients from receiving treatment from qualified medical professionals if such professionals do not receive admitting privileges at a nearby hospital. Such regulations are an unjustifiable interference with the free market, and they undermine patient liberty and autonomy. The decision of the court of appeals should be reversed.

Respectfully submitted.

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